COMMENT ON THE PROCEEDINGS*

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OUR distinguished speakers have offered some brilliant insights into the many problems of graduate medical education and have often pointed out that most of us are unwilling to experiment to solve our common problems. At least I did not hear many new experimental approaches proposed that were risky. I heard approaches that were experimental but also not threatening to the educational establishment.

The American Board of Internal Medicine's view of its training requirements and admissions to its examinations is an exceptional example of clear insight and willingness to take chances. It includes some of the most imaginative changes in residency education.

There were also comments about the totality and continuity of medical education. I think of medical education as a continuing process from the age of 18 until death or retirement—some of it formal, some tutorial, some practical, and some self-renewing.

When looked at that way, it does not really make much difference how intensive the first few years of education are, including the experiences in medical school. They obviously have to be of good quality, but the most important period of education might be that which begins after the residency and which continues through life. If that is so, then the question of whether one has a three-year or a four-year curriculum in medical school or two, three, or four years of college, while important, may no longer be of overriding importance for the future graduate.

An examination of the period of preparation for graduate medical education reveals that the four-year undergraduate program is generally of 36-months' duration, whereas the three-year program is usually 33

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months. The difference is largely one of vacation time. I am not arguing for one system or the other; I just think it is time we faced these facts. We must decide whether 36 versus 33 months is of importance to the quality of medical education, not whether four calendar years are important—unless emotional maturation requires four years at this period of life or can occur some other way. We must also decide how much or how little vacation medical students need in preparing to become residents, or what they should do with it. Those are the real questions, not the number of years.

The questions raised about graduate medical education—or education in college or medical school—may vary in emphasis if all of these stages related to continuing medical education after the residency period. Will we some day consider this last phase as the most important one? It is possible.

It does not make much difference what label is given to the process of continuing education. It may be termed recertification, relicensure, or continuing education. The main long-term education period of the typical physician or surgeon could be the 35 to 40 years following his residency. The education will of necessity be informal and it will occur as an interaction between the physician and the program he chooses rather than in the formal areas of education in which we are all so heavily involved at present. The formal aspects of medical education are essential, but they are only a prelude, in a sense, to this last neglected but important aspect.

The second central point dealt with in this symposium is the question of whether graduate medical education is meeting the country's health-care needs. Some speakers touched on this matter in provocative ways. Unfortunately, nobody really knows what the needs for medical care are in this country; at present there is no way in which we can assess them quantitatively. Organizations such as the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) will undoubtedly continue to try to evaluate more precisely what these needs are and who should meet them.

In relation to this, there was considerable discussion of costs. One aspect of cost was touched on to a small degree: i.e., the financing of all phases of medical education, including graduate medical education. One detects an increasing belief in society at large that the prospective physician and the practicing physician should be responsible for their

own educational financing. It is too early to predict the outcome, but this point of view is steadily gaining influential adherents.

The view is based upon the prevalent opinion that medicine is an affluent profession and that physicians who go into private practice have considerable earning capacity. Therefore, it is felt, they should be allowed to borrow large sums of money to finance their own education at all stages. This principle is important; it could have a major impact on medical education and the role of society in the support of all of the stages of training.

For the medical schools it is one solution—possibly a poor one—to some of their serious financial troubles. Everybody will be able to pay the cost of his own medical education—in fact may be required to do so.

There is also the possibility of having physicians pay back to the states the amount spent for subsidizing their individual medical educations. For instance, at one of the state university schools of medicine the tuition is $900 a year. The cost for each student is approximately $15,000 a year. It is expected that a physician benefiting from such a system will return approximately $15,000 less $900 to the state when he goes into practice, should the state enact these concepts into law.

It is essential to recognize the forces behind all this activity. There is a reservoir of consumer hostility to the medical profession, based on a belief that we are affluent beyond description. While people consider us important to the health care of the nation, there has been a diminution in sympathy for any form of public support for the medical profession because of the large incomes of practicing physicians.

Many interesting views were presented by the panel on the responsibility for graduate medical education, especially with regard to the nature of the residency: i.e., graduate medical education. One function of the resident is the care of patients, which can be accomplished in a variety of ways. An estimated 75% of the average resident's time is spent in caring for patients. The education of the resident apparently consumes less time than this service. However, the only way that we can educate a physician to do something is to see that he does it under guidance and that he does it well. This view inevitably blurs the distinction between the functions of service and education.

How much should the resident do and how should he do it? How does this experience lead to competence? Who decides what competence is? All the traditional answers were summarized magnificently

by Doctors John C. Beck and William P. Longmire. Are there any new approaches?

Should we have medical students, patients, layment, and junior faculty members complete evaluation forms? Should we ask them if the service was good? Is it of any importance to the director of a clinical service to know how these people feel about it? I do not know whether it is. I know of no board which certifies specialists that is truly interested in the views of the patients as well as those of students and residents. Perhaps we should consider what these groups think of both the care and the educational process.

We have heard a discussion at great length about the peer-review system. However, there should be more interest in getting help from the behavioral sciences, to quantify subjectively what we are doing with the peer-review system. Dr. Fredrick C. Redlich pointed out very well how difficult the peer-review system can be to administer and evaluate, although he was strongly in favor of it. How do we know, for example, whether a resident helps a psychiatric patient to get well? By what standards should we judge? In a surgical operation one can see whether the wound healed well, if the condition was corrected, or if the patient survived.

Dr. E. Hugh Luckey's opening remarks bear on all these issues. He suggested that federal training-grant programs were misused for clinical training in many instances. I believe that this is not an accurate judgement. Some programs contributed to the development of sorely needed practitioners: e.g., psychiatrists and anesthesiologists. Perhaps exploitation did occur at some institutions. However, in general the trainee program was one of the most effective contributions that the National Institutes of Health have made to the development of clinicians and other personnel who are needed to provide health care.

The conclusions of the Carnegie Commission and their impact on graduate medical education were incorrect in some aspects. For example, the commission claimed that shortening the course of graduate medical education makes it less expensive. But this actually increases the expense. Several of us have been involved with that problem and found that this is not a way to economize because of increased faculty expense and more rapid deterioration of physical plants.

Elective time, comprising approximately 25% of undergraduate medical education, was emphasized by the commission as valuable in

preparation for graduate medical education. I would also like to see elective time in the graduate period of medical education as well as in the undergraduate. But if it is to continue as it is now, elective time must be more closely monitored and controlled by departmental chairmen and deans. For example, I do not view an elective skiing experience in Switzerland to be a maturing influence with regard to the practice of medicine, enchanting though it may be for other reasons.

In this conference we also have heard much about the geographic maldistribution of physicians and health professionals. We should address ourselves to the solution of this vexing problem. No kind of graduate medical education can prepare physicians for solo, isolated practice, for instance, in a town of 8,000 people where the following events could be encountered any day: a head injury in an automobile accident, an arthritic hip which needs replacement, an episode of acute congestive heart failure, and a case of viral pneumonia. There is no way that even the best family practitioner could cope with all four problems; he must send these patients somewhere. We have to design systems of transport and screening that will function effectively. We still have not decided who should do the screening, nor have we developed effective systems of transport.

Dr. Eli Ginzberg pointed out that the prospect for support of graduate medical education from the federal government is poor. This view probably is accurate; but the prospects for some support from counties and cities are not nearly so pessimistic in those contractual arrangements which deal with that part of the resident's activity involving the direct care of the sick. It is not easy to obtain financial help for purposes of graduate medical education, at least in our experience. In the county in which I live the citizens voluntarily assessed themselves $88 million for the delivery of health care in an area of particular interest to the University of Miami. People can be persuaded to spend money when they believe that they will receive worthwhile health care in return.

The best test of continuing medical education is whether it betters the performance of the physician in his practice. This goal can be achieved by the physician who extends his knowledge by reading, going to seminars, or listening to tapes. Any of these methods can provide information and can also be a source of enjoyment.

Summary

I should like to summarize some of the points which require additional consideration. First, if the residency is the present prototype of graduate medical education, is it the best means to provide graduate medical education? Should there be alternatives and, if so, what should they be? What are the advantages and disadvantages of other methods? Should we not also look to other parts of our country and to other societies and cultures for their experiences?

Second, since continuing education may ultimately be a most important part of all medical education, in what way can graduate medical education be redesigned to develop in the physician a life-long curiosity and desire to remain competent and up to date?

Third, the schools of medicine, the AMA, the AAMC, practitioners of medicine, hospitals, and everyone in the health-care field share common problems which they must work more closely to solve.

Fourth, I have dealt with the cost of graduate medical education in an affluent society, in which the consumers of health care are often opposed to paying for it out of tax dollars. I have suggested one or two possible alternatives, but solutions still remain to be developed.

Fifth, I have examined the adequacy of peer evaluation of the residency systems. These criteria are insufficient; we should be able to develop more quantitative approaches to this subject. Perhaps our first step should be to follow the lead of the American Board of Internal Medicine in designing expert examinations which candidates are permitted to take whenever they and their teachers feel they are ready.

My last questions emphasize the need to reexamine the role of specialty boards. Should a board examine for professional competence only once? Should it think of reexamining at some later time? If so, what kind of examination should be used? Should the board give courses, such as the British Royal Colleges do, to prepare for its examinations? Should the boards, the universities, or both be involved in continuing medical education? Should the boards be interested in approving the training programs or should they do what Dr. John Beck has suggested: i.e., examine individuals? If the examination is careful enough, it may be able to separate the competent from the incompetent. Perhaps by examining these questions, we shall be able to do better when the day of quantification comes.